Joint Informational Hearing of the
Senate Committee on Health and the Senate Committee on Budget and Fiscal Review, Subcommittee No. 3 Health and Human Services

Chairs
Senators Deborah Ortiz and Denise Moreno Ducheny

"Governor's Proposed Medi-Cal Redesign

Wednesday March 2, 2005
1:30-5:00 p.m.
State Capitol, John L. Burton Hearing Room (4203)

Agenda

I. Welcome and Opening Comments

- ***Senator Deborah Ortiz,*** Chair, Senate Health Committee
- ***Senator Denise Moreno Ducheny,*** Chair Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services
- ***Other Members Present***

II. Medi-Cal Managed Care in California

- ***Stan Rosenstein***, Deputy Director for Medical Care Services and Rene Mollow, Assistant Director for Health Policy, Department of Health Services
- ***Howard Kahn***, Chief Executive Officer, L.A. Care and Local Health Plans of California
- ***Michael Murray***, Executive Director, San Mateo Health Commission and California Association of Health Insuring Organizations.
- ***Joanne Bovee***, Legislative Advocate, California Association of Health Plans
- ***Steve Hon***, Program Manager, County of San Diego Health and Human Services Agency
- ***James Hunt***, Director, Sacramento County Department of Health and Human Services
- ***Lisa Folberg***, Legislative Advocate, California Medical Association

- ***Barbara Glaser***, Legislative Advocate, California Hospital Association

III. Premiums

- ***Stan Rosenstein***, Deputy Director for Medical Care Services and Rene Mollow, Assistant Director for Health Policy, Department of Health Services
- ***Angela Gilliard***, Legislative Advocate, Western Center on Law and Poverty, Inc.
- ***Deena Lahn***, Policy Director, Children's Defense Fund California
- ***Dr Richard Pan***, MD, California Medical Association

IV. Single Point of Entry

- ***Stan Rosenstein***, Deputy Director for Medical Care Services and Rene Mollow, Assistant Director for Health Policy, Department of Health Services
- ***Frank Mecca***, Executive Director, County Welfare Directors Association of California

V. Adult Dental Services

- ***Stan Rosenstein***, Deputy Director for Medical Care Services and Rene Mollow, Assistant Director for Health Policy, Department of Health Services
- ***Liz Snow***, Public Policy & Strategic Development, California Dental Association
  Dr. Irving Lebovics, DDS, Representative, California Dental Association

VI. Public Comment

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Governor's Proposed Medi-Cal Redesign
Staff Briefing Paper

Medi-Cal Overview
Medi-Cal is a publicly-funded program that provides health coverage to 6.6 million low-income children, their parents, senior citizens and disabled Californians or about one in five Californians. A versatile program, Medi-Cal covers about 25 percent of California's children, many living with AIDS and supplements Medicare for low-income elderly and persons with disabilities. The State Department of Health Services (DHS) administers the program with the federal government providing a matching Medicaid reimbursement rate of 50 percent.

According to DHS, California operates one of the most cost-effective Medicaid programs. Among states, California spends less per beneficiary. Nevertheless, the program is the second largest in the state budget, ranking only behind K-12 education.

Medi-Cal Redesign
According to DHS, Governor Schwarzenegger is proposing to redesign Medi-Cal in order to maintain health care coverage for eligible Californians while containing costs and achieving efficiencies.

The main elements of the redesign proposal are:

- **Managed Care Expansion:** This proposal expands managed care in several ways. First, managed care is increased from the current 22 counties to 13 additional counties. The second element of the expansion is the mandatory enrollment of certain seniors and persons with disabilities in those 35 managed care counties. (Mandatory enrollment for seniors and persons with disabilities is already required in the 8 counties that are services by County Organized Health

Systems.) In addition, there is a pilot project for acute and long-term care integration in three counties.

- **Stabilizing California's Safety Net Hospitals:** This is proposed to be achieved through a new five-year Medi-Cal financing waiver with the federal government. This proposal represents a comprehensive redesign of a significant portion of hospital funding. It will include replacing intergovernmental transfers with federally-acceptable sources of funding and replacing the current funding method with new methods that can optimize the amount of federal funds drawn down. A major objective is to preserve hospital financing for the uninsured irrespective of whether Medi-Cal beneficiaries are served through fee-for-service or managed care.

- **New Medi-Cal Premiums**: The Governor's proposal will institute monthly premiums for individuals with incomes above 100 percent of the federal poverty level. The federal poverty level is defined as monthly income of $1306 for a family of three. The premium amounts will be $4 per month for each child under 21 and $10 for adults. The premiums are capped at $27 per month per family.

- **Single Point of Entry Changes:** This proposal will alter the Medi-Cal eligibility determination process for children whose applications are submitted through the Health Families Program vendor, known as the Single Point of Entry. Medi-Cal applications received by the vendor will be processed by the vendor. The current practice is to forward to a county for processing.

- **Limit on Adult Dental Services:** The proposed limit will be $1,000 in a 12-month period. According to DHS this benefit will cover the majority of a beneficiary's dental needs. This limitation excludes the costs of federally mandated dental services, emergency services and hospital costs associated with dental treatment.

- **County Performance Standards Monitoring:** This aspect of the redesign proposal will secure a vendor to monitor county compliance with state and federal standards pertaining to eligibility determinations and annual redeterminations. Currently, the counties report about compliance, but the state does not verify these efforts. Under this proposal, if there is a lack of compliance, fiscal sanctions will be pursued.

Previous Hearings

This hearing builds and complements earlier hearings on this subject:

- On February 17, 2005 the Senate Budget and Fiscal Review, Subcommittee No. 3 on Health and Human Services held a hearing on the hospital financing, managed care and premium portions of the redesign plan.

- On August 11, 2004 the Senate Health and Human Services Committee held a hearing on the likely issues to be raised by Medi-Cal redesign, including waivers, enrollment caps, cost sharing and premiums.

The hearing today will address the single point of entry and the limit on adult dental services while focusing further on managed care expansion and premiums.

The following staff report contains these sections:

Proposed Managed Care Expansion

Summary of Existing Medi-Cal Managed Care System: DHS is the largest purchaser of managed health care services in California. Currently, some form of **Medi-Cal managed care serves about 3.2 million Medi-Cal enrollees**, primarily families and children and is **in 22 counties**. **Only 280,000 enrollees, or about 9 percent, are seniors and individuals with developmental disabilities.**

The Medi-Cal managed care system utilizes three types of contract models:

- Two Plan. About 74 percent of Medi-Cal managed care enrollees are in a Two Plan model which covers 12 counties.
- County Organized Health Systems (COHS). There are five COHS (federal law limit) that serve eight counties.
- Geographic Managed Care (GMC). The GMC model is used in two counties.

For people with disabilities, enrollment is *voluntary* in the Two Plan and GMC model, and *mandatory* in the COHS.

In addition, certain services are "carved-out" of the Two Plan and GMC models, as well as some of the COHS'. Most notably, Mental Health Managed Care, and the California Children's Services (CCS) Program are "carved-out", except for CCS in some selected counties which operate under the COHS model. Per existing state statute, CCS is carved-out until September 1, 2008.

Two Plan Model (in 12 Counties): The Two Plan model was designed in the late 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, other children and families, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are in this model.

Two Plan Model—Plans and Enrollment

Plan Name	**County**	**June 2003 Enrollment**
Alameda Alliance for Health (LI)	Alameda	73,840
Blue Cross of California	Alameda, Contra Costa, Fresno, Kern, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	360,760
Contra Costa Health Plan (LI)	Contra Costa	41,909
Health Net	Fresno, Los Angeles, Tulare	579,588
Kern Health Systems (LI)	Kern	69,432
La Care Health Plan (LI)	Los Angeles	824,271
Inland Empire Health Plan (LI)	Riverside, San Bernardino	232,318
Molina Healthcare of California	Riverside, San Bernardino	91,702
San Francisco Health Plan (LI)	San Francisco	28,796
Health Plan of San Joaquin (LI)	San Joaquin	56,046
Santa Clara Family Health Plan (LI)	Santa Clara	66,812
Two Plan Model Total		**2,425,474**

Geographic Managed Care (GMC): The GMC model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. In Sacramento and San Diego counties, DHS contracts with nine health plans that serve about 10.6 percent of all Medi-Cal managed care enrollees in California.

Geographic Managed Care—Plans and Enrollment

Plan Name	County	June 2003 Enrollment
Blue Cross of California	Sacramento and San Diego	92,173
Community Health Group	San Diego	66,086
Health Net	Sacramento and San Diego	39,558
Kaiser Foundation Health Plan	Sacramento and San Diego	29,049
Molina Healthcare of California	Sacramento	20,208
Sharp Health Plan	San Diego	50,238
Universal Care	San Diego	12,810
UC San Diego Healthcare	San Diego	13,344
Western Health Advantage	Sacramento	15,713
TOTAL		**339,179**

County Organized Health Systems (COHS) (Eight Counties): Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model). With the mandatory enrollment of all Medi-Cal beneficiaries there is no fee for services in these counties.

The capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in each county.

As noted in the chart below, **about 540,000 Medi-Cal recipients** receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about 9 percent of all Medi-Cal enrollees. **Federal law mandates that only 10 percent of all Medi-Cal enrollees can participate in the COHS model and the state is close to meeting this enrollment limit.**

County Organized Health Systems—Plans and Enrollment

Plan Name	County	June 2003 Enrollment
Cal Optima	Orange	281,839
Central Coast Alliance for Health	Monterey, Santa Cruz	84,363
Partnership Health Plan	Napa, Solano, Yolo	77,704
Health Plan of San Mateo	San Mateo	45,742
Santa Barbara Regional Health Authority	Santa Barbara	50,276
TOTAL		**539,924**

Overview of the Administration's Proposal: The Administration's Medi-Cal managed care expansion would be achieved through **a phased-in process over a twelve to eighteen month period commencing in January 2007.** The Administration's proposal would require **(1)** state statutory changes, **(2)** approval of a federal Waiver, and **(3)** adoption of state regulations.

It is anticipated that 816,000 additional Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion. These 816,000 new enrollees, of whom 554,000 would be aged, blind or disabled, would represent an increase of over 25 percent.

Dual eligibles (i.e., Medi-Cal and Medicare) would be excluded from mandatory enrollment except in COHS and in certain newly proposed Long-Term Care Integration projects.

The table below displays the Administration's assumed fiscal impact. DHS notes that time is needed to assure that appropriate delivery systems are in place before managed care is expanded. As such, initial costs will be incurred before out-year savings are realized.

In addition, particularly in 2007-08, DHS states that as individuals transition from fee-for-service to managed care, the payment of costs for services already rendered under fee-for-service are due at the same time as the monthly capitation arrangements to managed care plans (capitation payments are made for the month of enrollment without payment lags). Therefore, costs are incurred as the transition transpires.

Administration's Fiscal Impact Summary from Managed Care Expansion

Fiscal Year	Assumed Increase In Enrollees (average mthly)	Local Assistance (General Fund)	State Support (General Fund)	Net Total (General Fund)
2005-06	0	$150,000	$3,262,000 (47.5 positions)	$3,412,000
2006-07	61,000	$36,836,000	$3,262,000	$40,098,000
2007-08	538,785	$51,390,000	$3,262,000	$54,652,000
2008-09	820,239	($88,749,000)	$3,262,000	($85,487,000)

If the managed care expansion is fully implemented as proposed, about 60 percent of all Medi-Cal recipients would be enrolled in an organized delivery system.

In addition to individuals who would not be enrolled in managed care, such as rural residents, DHS states that about 17 percent of all applicants who qualify for Medi-Cal managed care are in "transition". These individuals in "transition" are either in the process of being determined eligible for Medi-Cal or are awaiting enrollment into managed care. During this transition period, health care services are being provided on a fee-for-service basis. Also outside of managed care are those who receive services in the months they pay a share of cost.

The proposed expansion assumes the following key components:

Expansion to 13 New Counties. The Administration would expand Medi-Cal managed care to 13 additional counties, **including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura.** Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

The Administration assumes the following managed care model configurations for these new counties:

- Include El Dorado and Placer counties in the existing Sacramento GMC;
- Include Imperial County in the existing San Diego GMC;
- Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
- Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

The Administration assumes that all of these counties are ready for enrollment no later than April 2008.

Aged, Blind and Disabled Individuals (Mandatory Enrollment). DHS has identified **36 Medi-Cal aid codes** which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. DHS assumes that **about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09. This increase represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).**

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

Acute and Long-Term Care Integration. The Administration also proposes implementation of Acute and Long-Term Care Integration Projects (Projects) in Contra Costa, Orange, and San Diego counties. Dual eligibles (Medicare and Medi-Cal) living in these counties would be enrolled. These counties were chosen because of existing managed care and their interest in participating in the pilot project.

DHS states that these Projects would offer a comprehensive scope of services that manages the full continuum of health care needs, including primary care, case management, acute care, long-term care, dental services, emergency services, and drugs.

Staff Comments--Key Considerations and Concerns: The Administration's proposed managed care expansion **is very ambitious, particularly given the state's history with past Medi-Cal managed care expansion efforts, including recent problems in Fresno County as well as in Stanislaus County.**

Aged, blind and disabled individuals require more extensive specialty medical care services, personalized durable medical equipment, and rehabilitation therapists who have experience with serving these medically-involved individuals. As such, issues pertaining to physician networks, access to durable medical equipment and related needs will need to be comprehensively addressed prior to any transition for these individuals.

The expansion into new counties, coupled with a mandatory enrollment of aged, blind and disabled individuals, may be too much to accomplish successfully within the 12 to 18 month period designated by the Administration. This is particularly true when it comes to transitioning very medically-involved individuals from providers they know and who know them and their condition to a new network of providers.

If this expansion is to occur, comprehensive planning with impacted constituency groups, particularly stakeholders in the mental health and developmental disabilities communities, needs to occur. Ongoing involvement from local communities, as presently done in San Diego County, should also be a requirement.

In addition, considerable fiscal issues, including resolution of complex hospital financing concerns and the development of meaningful managed care rates, need to be further studied and resolved if aged, blind and disabled individuals are to be required to be enrolled. If rates are not appropriate, people will not receive necessary medical services or the state will be unable to attract health plans.

It is well known that the COHS have been experiencing fiscal hardship in serving these very medically-involved individuals. In fact, the Budget Act of 2004 provided a 3 percent rate increase to the COHS due to low operating reserves and questions of fiscal solvency.

Key factors for the state to evaluate health plan readiness of any managed care arrangement includes: (1) analysis of available service utilization and cost data; (2) network adequacy; (3) care coordination and carve-outs; (4) quality monitoring and improvement; (5) linkages with non-Medi-Cal services; (6) accessibility and availability of new treatment modalities; (7) community, provider and consumer input into the planning process; and (8) health plan and provider compliance with the Americans with Disabilities Act of 1990.

The inclusion of aged, blind and disabled individuals (36 new aid codes) would require an expanded state evaluation to determine health plan readiness**.** In conjunction with the federal CMS, DHS would conduct readiness reviews of all Medi-Cal managed care plans prior to health plans becoming operational to serve this population. Specifically DHS states that they would use the readiness model established under the COHS process. However, more analysis of this approach is needed in order to discern what factors are to be measured and what quality assurances will be put into action. Clearly, more detailed

discussions with constituency groups and the Legislature are needed prior to any agreements for expansion.

Proposed Implementation of Premiums

What is the Administration's Proposal? Under this proposal, effective January 1, 2007, Medi-Cal enrollees with **incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage.**

The 100 percent of poverty threshold represents **(1)** $1,306 per month for a family of three, **(2)** $812 a month for a senior, or disabled individual, and **(3)** $1,437 a month for a couple receiving SSI/SSP.

The proposed premium amounts are as follows:

- $4 per month for children under 21 years;
- $10 per month for adults; and
- $27 per month maximum for a family.

For example, a family of three with a monthly earned income of $1,306 per month would pay $24 per month for coverage or $288 annually. The required premium payment represents about 1.5 to 2 percent of the total annual income for the affected individuals.

Enrollees would be dropped from Medi-Cal if they do not pay premiums for two consecutive months. If re-enrollment is pursued, the individual would be required to pay back premiums owed from the previous six months in which they were enrolled. This can become confusing due to Medi-Cal eligibility retroactivity (which is 90-days) as allowed by federal law.

Counties would conduct a premium calculation to discern if the Medi-Cal eligible person needed to pay a monthly premium. DHS would contract with a vendor to conduct the actual collection of the premiums each month.

What are the Criteria for Determining a Premium? Premiums will be required of any family, child, or other individual who have incomes above 100 percent of the poverty level, **except for (1)** individuals with a share-of-cost (they spend down to become eligible for Medi-Cal), **(2)** 1931 (b) families enrolled in CalWORKS, **(3)** infants under one year of age, **(4)** American Indians, and **(5)** Alaskan Natives.

Therefore, the primary categories of Medi-Cal enrollees to be impacted by the proposal are:

- Children ages one to six with family incomes above 100 percent, and up to 133 percent, of poverty;
- Seniors and individuals with developmental disabilities with family incomes above 100 percent, and up to up to 133 percent, of poverty; and

- 1931 (b) families with incomes above 100 percent, up to 155 percent, of poverty ($2,024 per month for a family of three), and not enrolled in CalWORKS.

However, 1931 (b) families would be treated *differently* with respect to how the Administration makes the premium determination. The Administration proposes to change how the existing earned income deduction will be applied solely for the purpose of determining premiums. In effect, when determining whether premiums are to be paid, a different calculation will be used (i.e., allowing for only a $90 income disregard in lieu of the $240 and ½ disregards). **Therefore, the result under this revised calculation is that more families will need to pay premiums because they will be considered above the 100 percent of poverty level.**

Further, families enrolled in the 1931 (b) category will have difficulty re-enrolling into Medi-Cal if they are disenrolled due to failure to pay a premium. These "recipients" are usually individuals who have left CalWORKS and receive Medi-Cal-only services. The federal Welfare Reform Law of 1996 specifically authorized these individuals to receive Medi-Cal services because Congress wanted to transition individuals from welfare to work. One of the barriers to this transition was receipt of health care services. As such, 1931 (b) families can have incomes up to 155 percent of poverty and be eligible for Medi-Cal. However if they loose their existing eligibility, they would be eligible for Medi-Cal-only if their income level was at 100 percent of poverty or below.

Who are Affected and How is Enrollment Impacted? This proposal would affect children, aged, blind and disabled individuals, and families. **A total of about 550,000 people would be required to pay a premium, including about 460,000 families with children, and 90,000 seniors and individuals with disabilities with incomes above the SSI/SSP level.**

In the first year alone, **DHS assumes that almost 20 percent of these individuals or about 94,630 individuals will fail to pay and become disenrolled,** and thereby add to the increasing ranks of the uninsured living in California. This is illustrated in the table below.

It should be noted that DHS assumes that *all dual eligibles* (Medicare and Medi-Cal eligible) will *not drop off* because Medi-Cal pays their Medicare premiums. However in practice this may not occur; therefore, even more individuals could fail to make the premium payment.

DHS' Assumptions of Who Loses Coverage

Eligibility Category (Fee-for-Service & Managed Care)	**Total Medi-Cal Enrollees Needing to Pay**	**Reduction in Enrollees (Drop-Off)**
Aged, Blind & Disabled	90,601	2,817 (3%) (Assumes no duals are dropped)
Children	207,030	41,404 (20%)
Adults (ages 21-64)	252,045	50,409 (20%)
TOTALS	**549,676**	**94,630**

Medi-Cal Eligibility Processing — Likely Churning of Enrollees: **The proposal is almost certain to result in a churning of enrollees and increase administrative processing costs.**

First, under federal law, as well as state law, (SB 87 (Escutia) Statutes of 2000), individuals who loose Medi-Cal eligibility under one set of criteria may be eligible for Medi-Cal enrollment under another category. **As such Medi-Cal re-determinations must be made. Therefore, all of the Medi-Cal enrollees who are discontinued from Medi-Cal due to non-payment of premiums would conceivably need to be re-determined by the counties.**

Medi-Cal re-determination processing can require considerable work on the part of counties. Under re-determination processing, a county must first do an "ex parte" review. Under ex parte, the county must check certain public assistance data systems to see if there is appropriate information to make an eligibility determination. If not then additional information is obtained as needed from the individual through telephone contact and if needed, use of a special Medi-Cal form. **These administrative costs have *not* been addressed by the Administration's proposal.**

Second, as noted by the Administration's own analysis, individuals will drop-off due to the non-payment of premiums and then come back on when they need services (if eligible). **This churning of enrollees seems contrary to the Administration's own goal of expanding Medi-Cal managed Care. Managed care plans would not appreciate having Medi-Cal enrollees coming in and out of enrollment. This could also result in additional processing costs for the Medi-Cal Health Care Options contractor** since they will need to inform enrollees of their health plan choices and enroll them into a plan.

Third, it is unclear how the "Medi-Cal Eligibility Determination System" (MEDS) could maintain its data integrity. Counties maintain MEDS since they perform most Medi-Cal eligibility processing. In the event of Medi-Cal enrollees discontinuing due to non-payment of a premium, it is unclear how the Vendor will notify the county of this action. **If the two systems are not in synch with each other, the state could be making managed care plan payments for individuals no longer eligible for Medi-Cal, or Medi-Cal enrollees could be inadvertently disenrolled from Medi-Cal.**

Fourth, it is unclear how the continuous annual eligibility enrollment of children would be affected if premiums were not paid (such as in the 133 percent of poverty program). The original policy and fiscal concepts behind this annual enrollment was to ensure coverage for children and to reduce administrative costs. It appears that these would not be achieved under the proposal.

Fifth, a clear mechanism for re-enrollment would need to be established, or people's applications could be put on hold indefinitely while they are being asked to pay the premium. What if a parent or child requires medical attention while they are on hold? Should the family spend their money on the medical care, or on paying back their premiums? How will providers of health care know clearly what the status of an individual patient is at the moment of the health care delivery?

Proposed Administrative Costs Do Not Reflect All Necessary Expenditures: **The table below displays** the DHS' estimated expenditures for the administration of the premium. As noted below, they assume first year (i.e., 2005-06) implementation expenditures of $6.850 million General Fund, with on-going annual expenditures of **at least** $12.150 million General Fund.

However, not all of the expenditures are captured in the DHS' cost assumptions. First, no additional county administrative costs have been recognized for conducting Medi-Cal re-determinations as discussed above.

Second, the DHS fiscal summary assumes that counties would calculate a premium one time, and that would be it. However, in the reality of life, people may lose their job or have their hours reduced, get married, have a baby, or other related life events that would result in them no longer having a premium requirement. **As such, additional administrative costs for calculating the premium would probably be needed.** In addition, would a family have to pay while their premiums are being re-determined? If they didn't pay, would they be inappropriately dropped off of Medi-Cal?

Third, expenditures for a contractor to *design* a premium collection system are not included, though expenditures for the actual collection of the premium are included. It is likely that development and design of an information system would be costly. **DHS notes that it is unknown at this time what these costs would be.**

DHS assumes that it will take at least 18 months for the "premium collection contractor" to develop a collection system and begin actual collection (assumes premiums begin to be paid as of January 1, 2007).

Administrative Expenditures for Premium

Administrative Activity	**Proposed Expenditures (General Fund) 2005-06**	**Proposed Expenditures (General Fund) 2006-07** *(1/1/2007 start)*	**Proposed Expenditures (General Fund) 2007-08**
I. DHS Identified Costs			
County Determination of Premium	$6,200,000 (850,000 cases to review)	$7,200,000 (950,000 cases to review)	$7,200,000
Contract—Collection of Premiums	---	$2,150,000	$4,300,000
DHS State Staff (positions)	$650,000	$650,000	$650,000
Subtotal--DHS' total amount	**$6,850,000**	**$10,000,000**	**$12,150,000**
II. Unidentified Costs			
County Re-determination Costs		**Unknown**	**Unknown**
County Re-Enrollment Costs		**Unknown**	**Unknown**
County Premium Re-Calculation		**Unknown**	**Unknown**
County MEDS Linkage to Vendor		**Unknown**	**Unknown**
Vendor Design, Development and Maintenance of System		**Unknown**	**Unknown**
Health Plans Options Processing		**Unknown**	**Unknown**

Administration's Assumptions Regarding Savings: As shown in the table below, the Administration **assumes savings from the premium payments from two sources: (1)** the revenue received from the payment of the monthly premium, and **(2)** from health care costs not provided to individuals because they have dropped off of Medi-Cal due to the non-payment of the premium. These assumptions are open to interpretation since limited research data is available.

It is interesting to note that the Administration assumes no savings for in-patient care services from those individuals who are dropped off of Medi-Cal due to non-payment, and only from two to five percent savings from non-institutional care. This is because the Administration recognizes that individuals will come on and off Medi-Cal as they need services. As such, it decreases the likelihood of "managing" care.

As noted below, the Administration assumes savings of from about $15 million General Fund to about $23 million General Fund on an annual basis. However, as previously discussed, it is unlikely that all costs associated with administration of this program have been captured.

Administration's Assumed Savings from Premium Payments *(Annualized)*

2007-08 First full year (Annualized)	Aged, Blind & Disabled ($10 for 12 mths)	Children ($4 for 12 mths)	Adults (Ages 21-64) ($10 for 12 mths)	**Total Funds**
***Net* Premium** (After drop-off)	**$10,534,000** (87,783 people)	**$7,951,000** (165,627 children)	**$24,225,000** (201,636 people)	**$42,708,000** (455,046 people)
Dropped from Medi-Cal	2,817 People (3%)	41,404 Children (20%)	50,409 Adults (20%)	94,630 Total
2 % to 5 % Savings for Dropped People	$1,163,000 to $2,908,000	$3,697,000 to $9,244,000	$5,433,000 to $13,584,000	$10,295,000 to $25,735,000
SUBTOTAL	**$11,697,000 to $13,442,000**	**$11,648,000 to $17,195,000**	**$29,658,000 to $37,809**	**$53,003,000 to $68,443,000**
DHS' Assumed Administrative Costs				-$23,044,000
Administration's Net TOTAL (Rounded)				**$29,958,000 to $45,399,000**
Assumed General Fund Savings				**$14,979,000 to $22,700,000**

Administration's Proposed Implementation: The premium proposal **would require state statutory change as well as a federal Waiver.**

The Administration assumes approval by the Legislature during the 2005-06 Session and that a Waiver would be submitted to the federal CMS by December 2005. DHS notes that the federal Waiver process might take from six to nine months from this date for approval. The Administration notes that the state contracting process typically takes 15-21 months once their Request for Proposal (RFP) is released. Therefore, the Administration assumes that premium payments and collections would begin January 2007.

Single Point of Entry
Proposed Processing Change for Children's Applications

Background—What is the Existing Single Point of Entry Process? Presently, **joint applications for children** (Medi-Cal and Healthy Families) are submitted to a "Single Point of Entry" where they are initially processed by the Healthy Families Program

(HFP) vendor. The HFP vendor processes the HFP eligibles and then makes an *initial* determination when an applicant appears to be eligible for Medi-Cal

The Medi-Cal applications are then sent by the HFP vendor to the individual's county of residence. The county then makes the final Medi-Cal eligibility determination. **As required by both federal and state law, county eligibility systems work through a progression of eligibility determinations in order to identify which category of eligibility is the most appropriate for the child.**

The 1931 (b) category of eligibility is the broadest category of eligibility for children. The key aspect of being enrolled in this program is that they receive at least six months of Transitional Medi-Cal if they become ineligible for Medi-Cal at any point during their 12-month eligibility period due to increased family income.

The next broadest category is "regular" Medi-Cal because children are given a larger income disregard than in the "percent" programs if anyone in the family is aged, blind or disabled. In addition, applicants are also allowed to deduct child care costs and eligibility extends to age 21 in this category.

The "percent" programs provide Medi-Cal coverage for (1) infants up to age 1 with family income up to 200 percent of poverty, (2) children aged 1 through 5 with family income up to 133 percent of poverty, and (3) children aged 6 through 18 up to 100 percent of poverty. Unlike the 1931 (b) program and regular Medi-Cal, these percent programs disregard the value of property owned by the family. Children aged 19 and over are not eligible for coverage under these percent programs.

Governor's Proposal to Change the Single Point of Entry: Under this proposal, Medi-Cal applications for children received through the "Single Point of Entry" would now be completely processed by the HFP vendor and then sent to the state for final certification. The state would then send the completed Medi-Cal application to the appropriate county for ongoing case management, including annual redeterminations. **DHS assumes that about 85,000 applications would be processed in this manner.**

The table below displays the *net* costs to the state for this proposal in 2005-06 which are $6.8 million ($2.1 million General Fund). This includes increased costs for 19.5 new state positions, as well as vendor contract expenditures and information system changes. It should be noted that the Healthy Families Program inadvertently did not capture the increased costs for the vendor processing in their budget. This is to be corrected in their May Revision.

Summary of Expenditures for Single Point of Entry Changes (2005-06)

Governor's Proposed Single Point of Entry (2005-06)	DHS (Total Fund)	DHS (General Fund)	Healthy Families Program (General Fund)
Local Assistance			
Program Savings	($210,000)	($105,000)	
County Administration	($2,182,000)	($1,091,000)	
Vendor Contract Costs	$1,150,000	$0	$1,150,000
Local Assistance	**($1,242,000)**	**($1,196,000)**	**$1,150,000**
Support Cost (19.5 new state positions)	**$6,909,000**	**$2,172,000**	
Additional Costs ($2.1 million General Fund)	**$5,667,000**	**$976,000**	**$1,150,000**

The Administration contends that savings of $9 million ($7 million General Fund) will be generated annually from this proposal once fully implemented. The savings generated from the proposal would primarily come from children being removed from Medi-Cal. Presently, when the HFP vendor does the initial Medi-Cal screen and the child seems initially eligible for Medi-Cal, the child is placed on "interim status" and is eligible to receive Medi-Cal services pending final determination being conducted by the county of origin. As such, there are some children who receive services who are later found to be ineligible for Medi-Cal and are subsequently disenrolled. The Governor's new proposal would change this practice.

Staff Comments: Additional information needs to be obtained as to how this restructuring of the Single Point of Entry is to actually work, including information systems processing changes, coordination between the HFP vendor, state, and counties, and related matters. For example, extensive changes to the Medi-Cal Eligibility Determination System (MEDS) and related systems needs to be completed before this can work.

On the surface, the proposal does not appear to actually streamline the process. Further, there may be other options available for improving the existing system that need to be explored.

Adult Dental Services

Governor's Proposal to limit Adult Dental Services at $1,000 per 12-month period

Summary Background—What is the Denti-Cal Program? Individuals enrolled in Medi-Cal are eligible to receive a range of dental health care services. Access to dental services for children under age 21 is required by federal law, whereas adult dental services are considered optional.

Generally, covered dental benefits for children and adults include:

- diagnostic and preventive services such as examinations and cleanings
- restorative services such as fillings
- oral surgery services.

Many services such as crowns, dentures and root canals require prior authorization.

State law requires most Medi-Cal enrollees to pay a co-payment for dental care. A $1 co-payment is required for services provided in a dental office and a $5 co-payment is required for non-emergency care provided in an emergency room. As directed by federal law, services cannot be denied to a recipient if a co-payment is not provided

Over 90 percent of Medi-Cal enrollees are eligible for fee-for-service care through the Denti-Cal Program. In addition, about 350,000 individuals receive dental services through managed care arrangements (including Sacramento, San Bernardino, Riverside and Los Angeles).

The reimbursement rates currently paid under Denti-Cal are very low—generally about 40 to 50 percent of the usual and customary fee charged by dentists in California.

Governor Schwarzenegger's Proposed $1,000 Cap on Denti-Cal: The Governor proposes savings of $48.2 million ($24.6 million General Fund) in 2005-06 in local assistance by restricting the amount of dental services provided to adults to $1,000 in any twelve-month period. An implementation date of August 1, 2005 is assumed. This proposal requires trailer legislation to enact.

DHS states that the $1,000 limit would not apply to:

> **(1)** Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in serious impairment to bodily functions;
>
> **(2)** Medical and surgical services provided by a dentist which, if provided by a physician, would be considered physician services, including complex maxillofacial surgical procedures and comprehensive oral reconstruction; and

(3) Services that are federally mandated under 42 Code of Federal Regulations, Part 440, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

As noted in the table below, about 95,000 Denti-Cal enrollees would be affected by the $1,000 limit. DHS has not been able to provide data regarding what procedures these individuals required and how they would be affected by the limit if one is implemented. For example, it is possible that all of the 95,000 would lose a similar, moderate number of services each year under the limit. However, another scenario could be that a small portion of the 95,000 would lose a significant number of services, while the rest would see a smaller reduction.

Average Monthly Adult Eligibles Impacted by Proposed Cap

Type of Adult Eligible	Total Adult Eligibles	Eligibles Impacted by Cap
Aged, Blind, Disabled	1,447,500	52,900
All Other Adults (21-64 years)	1,552,000	42,000
Total	2,998,500	94,900

Based on the data provided by DHS, it is unknown at this time how many of the potentially affected eligibles may be enrolled in California's Regional Center system which provides services to eligible individuals with developmental disabilities**. This is a key issue since it is likely that the Regional Center system would incur additional General Fund expenditures to provide dental services which fall above the $1,000 cap.**

It is also unclear at this time on how DHS will be tracking dental expenditures to discern when an enrollee is about to exceed the cap. The Administration assumes expenditures of $4 million ($1 million General Fund) for a tracking system; however it is not clear as to what this specifically includes. Any tracking system would need to track each adult Denti-Cal enrollee's annual expenditures. Participating Denti-Cal providers would need to have access to the tracking system in order to clearly know if their patient was near the expenditures limit.

Further, if the pending treatment is to exceed the $1,000 limit, does the Denti-Cal provider complete the procedure and collect on the difference or what exactly? The Administration's proposal is not clear on this aspect of providing or denying treatment.

With respect to state support, DHS is seeking an increase of $165,000 ($59,000 General Fund) to hire one Associate Information Systems Analyst and a half-time Staff Counsel to implement the proposal.

Finally, it should be noted that DHS intends to implement this proposal through all county letters, provider bulletins, or similar instructions. Thereafter, DHS *may* adopt regulations.

Staff Comment: The Administration seeks to implement a $1,000 cap in Denti-Cal in an effort to align benefits more closely to the commercial market place. However, Denti-Cal is quite dissimilar to the commercial market place in several ways. It serves more medically needy individuals than the commercial market, reimburses at rates which are generally 40 to 50 percent of the usual and customary fee charged by dentists in California, and has eliminated or restricted services to enrollees due to budgetary constraints over the years. For example, Denti-Cal enrollees may only receive one dental cleaning annually where as the commercial market provides for two cleanings annually.

If a cap is to be implemented, consideration of a sunset date, rate adjustment factors, and the need for more preventive dental services, need to be discussed. Medi-Cal dental reimbursement rates are extremely low and placing a cap in statute without consideration for out-year implications is not constructive policy. Adequate access to dental services needs to be a part of the discussion.

Clarification on the proposal is also needed in order to better discern what specific procedures are exempt from the cap, as well as what dental services would fall above a $1,000 cap. For example, dentures cost $900 but other related dental work associated with this procedure would likely fall above the cap, such as related gum work or necessary medications, or root canal work related to the denture. DHS has provided a list of 13 Medi-Cal dental services with fees that exceed $1000 and four services with an exact fee of $1000. In addition they have provided a number of other dental treatment sequences that would probably exceed $1000 annually.

Finally, DHS should not be granted broad authority for implementation. Regulations which require public discourse, versus solely using “all county” letters or provider bulletins, should be used if any aspect of this proposal is adopted by the Legislature.